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Interagency collaboration in adult support and protection in Scotland

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Interagency Collaboration in Adult Support and Protection in Scotland: Processes and Barriers

Volume 2: Recommendations

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Our sincere hope is that the outcome of this research provides some return to them as they carry out the extremely complex and demanding task of protecting and supporting individuals who are at high risk of harm from a wide range of sources.

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SUMMARY

A detailed study of interagency collaboration in adult support and protection cases was undertaken between 2005-2007 in Scotland prior to the passing of the *Adult Support and Protection (Scotland) Act 2007* and its implementation in 2008. The detailed results of this research are reported in Volume 1 of this report. In that report we note examples of good practice and the very significant commitment of most staff to ensuring adults at risk of harm are protected. Here, in Volume 2, we make a series of recommendations based on the failings and shortcomings in the way in which the cases studied were conducted, or where issues were raised that require further consideration in order to improve practice.

The recommendations cover a wide range of issues, and have been grouped with respect to the principal agency or committee which should be responsible for implementation, i.e. the Scottish Government (section 2.1); the various departments and committees of the local authority (section 2.2); service providers (section 2.3); the Police (section 2.4); the National Health Service (section 2.5); the Care Commission (section 2.6). For each of the 26 recommendations we state the aim of the recommendation, the action required, how the outcome will be validated, the time scale for implementation, the result and the reporting mechanism with respect to implementation of the recommendation.

As noted at the outset of the report, the impetus given to improving practice in the field of adult support and protection in Scotland through implementation of the *Adult Support and Protection (Scotland) Act 2007* in 2008 has already led to extensive developments in this field. For some agencies some of the recommendations made may already have been met. However, we are very aware that this is not universally the case and improvement in this area must be an on-going process for many years to come.

We are also aware that though the recommendations are compartmentalised by agencies or committees, in reality most require collaborative interagency working. The location of a recommendation in the report should therefore be seen as indicating who principally should take the initiative, and not taken to indicate exclusive responsibility.



1 Introduction to recommendations

In Volume 1 of this report¹ we have described in considerable detail the activity of a range of agencies including the local authority, the National Health Service and the police in cases in which harm, abuse, mistreatment and neglect were alleged to have been perpetrated on widely contrasted individuals. These included older people with dementia, those with intellectual disabilities, physical disabilities, brain injury and less well defined difficulties in managing their own social lives. We described in detail a multiple research design in which case analysis, document analysis and interviews were carried out to establish in detail the way in which individual agencies and service providers responded to allegations. We also analysed the part played by alleged victims and their family members in the cases.

All cases studied took place before the passing of the *Adult Support & Protection (Scotland) Act 2007* and the Act's implementation in October 2008. The information collected, therefore, offers a basepoint against which to compare adult protection practice post the Act. It also points up a number of weaknesses in adult protection procedures at both agency and interagency levels that if remedied has the potential to improve practice in this area in the context of implementation of the Act.

In the present Volume 2 of our report we link specific recommendations to the principal agencies which would be responsible for their implementation. It is possible that in the context of the intensive implementation of the *Adult Support & Protection (Scotland) Act 2007* some of these recommendations in some local authorities are already being implemented. However, many should be seen as complementary to, or reinforcing, provisions in the Act and the associated guidance.

Though the present report summarises some of the relevant findings presented in Volume 1, it is not our intention here to re-present the study in any detail. The interested reader can refer back to Volume 1 for the evidence base.

2 Overall quality of adult support and protection

At the outset, it is important to comment on the extreme complexity of many cases of allegations of adult abuse in family settings, but also in managed facilities. The interpersonal relationships within families were themselves highly complex, with shifting dynamics and a wide range of external pressures creating a sometimes chronic, stressful environment. The historical experiences of family members could also play a significant part in family dynamics, influencing contemporary behaviour and attitudes to allegations. In two cases, for example, the effect of sexual abuse involving family members decades before was still being played out in the contemporary situation. In addition, these families were under scrutiny from

¹ Hogg, J., Johnson, F., Daniel, B. & Ferguson, A. (2009) *Interagency Collaboration in Adult Support and Protection in Scotland: Processes and Barriers. Volume 1: Final Report*. Dundee: White Top Research Unit, University of Dundee.

a variety of agencies with respect to the allegations that had been made and/or the concerns that had arisen. Within their stories, there is considerable poignancy and suffering.

Professionals, primarily social workers, addressed such family situations with many competing obligations to be met. Prevention of possible abuse had to be balanced with support for family members often including the alleged abuser. Evidence of abuse in such cases was often inconclusive but had sufficient face validity to demand sustained intervention. Alleged victims, sometimes sporadically and sometimes entirely consistently, did not wish to be "protected". In one case in which advice was sought from the Mental Welfare Commission, the commission was clear in its statement on the necessity of balancing the alleged victim's right to positive, if potentially risky, experiences and the social work department's duty to take protective action.

The legal context for intervention was also far from simple and involved close working with mental health officers and lawyers within the local authority. Social workers were also at the centre of a complex network of agencies and service providers all in varying degrees with information to provide and sometimes with a decisive potential role to play in addressing the allegations or their consequences. Expectations of each agency's role by the other agencies involved did not always coincide with that agency's actions or lack of actions, creating frustration with, and sometimes impeding, interagency processes. For example, social work departments had only limited influence over the input of other agencies such as NHS staff or the police, yet nevertheless were obliged to engage in interagency working with them. The wider political context also had to be considered, with the possibility of councillors or MSPs becoming involved.

When these two areas are brought together – the family context and the interagency context within which allegations of abuse are addressed – then the overall complexity of the situation is clear. Significant tensions could arise from differing judgements regarding support for an at-risk individual between social workers and the family and between social workers and professionals from other agencies.

That good practice in adult protection was possible was clearly evidenced in some of the cases reviewed. It is equally clear that however well intentioned, much adult protective practice fell short of being as effective as it should have been. In emphasising areas of possible improvement we are focusing on such shortcomings rather than suggesting that poor performance was the norm. Some of the recommendations we make will be seen in some authorities as having already been implemented, and indeed, the good practice noted has informed these. However, review of these aspects of adult support and protection is still merited.

In line with the concordat between The Scottish Government and COSLA, direction to the whole adult support and protection initiative in Scotland has been given by the Scottish Government, principally through enactment of the

Adult Support and Protection (Scotland) Act 2007 and the related, extensive implementation programme taking the provisions of the Act forward. At local level, the establishment of Adult Protection Committees has placed a statutory obligation on these committees to ensure that appropriate and robust procedures are in place to ensure effective adult protection. These committees are responsible for interagency collaboration between local councils, the NHS, the police, the Scottish Commission for the Regulation of Care and a wide range of statutory and voluntary agencies. Below we summarise the principal findings of the research that underpin the recommendations and link these to the agencies just noted. Clearly each agency or body can only implement the recommendations in collaboration with their partners as part of their on-going multiagency work.

2.1 SCOTTISH GOVERNMENT

As described above, the Scottish Government took the initiative with respect to the introduction of adult protection legislation and the extensive programme of training and awareness raising that has followed. Joint work to implement the *Adult Support & Protection (Scotland) Act 2007* is specifically cited in the concordat between the Scottish Government and COSLA. The nature of the implementation programme, however, locates most of the recommendations that follow firmly at the local level, with special responsibilities falling to the Adult Protection Committees established under the Act.

There are, however, some overarching issues which we would recommend that the Scottish Government takes a national initiative on. At present the development of education and training in the field of adult protection is developing across a wide range of higher education institutions. We recommend that the Scottish Government facilitates collaboration between bodies overseeing initial and post-qualifying/registration training, course designers, professionals directly involved in practice and researchers to ensure that training reflects the available body of evidence and good practice (Recommendation 1). Further areas in which a lead can be taken relate to clarification of the criteria for initiating an adult protection process (Recommendation 2) and with respect to the process of risk assessment (Recommendation 3).

Recommendation 1: The Scottish Government should undertake a development event with all relevant bodies overseeing initial and post-qualifying/registration training and education in adult protection in order to ensure that training and education address the key objectives of Scottish Government policy.

Aim: *To ensure that adult protection training and education in Scotland addresses key national policy objectives.*

Action:	<i>The Scottish Government should convene a conference of professional bodies responsible for training and education to review available courses and initiatives in these areas from the perspective of national policy objectives.</i>
Validation:	<i>Post-conference review of training and education.</i>
Time scale:	<i>Conference to be held April 2010 and review of training and education October 2010.</i>
Result:	<i>Post-qualifying/registration training of all relevant professional groups facilitate implementation of national objectives in adult support and protection.</i>
Reporting:	<i>Scottish Government Adult Support and Protection Division reports to Minister on outcomes.</i>

Recommendation 2: The Scottish Government Implementation Group should constitute a sub-group to develop a flexible but consistent approach to risk assessment with special reference to determining thresholds for adult protection interventions.

Aim:	<i>To achieve consistency and convergence of judgements on the threshold for adult protection intervention when allegations of harm are made.</i>
Action:	<i>Criteria for action should be formulated by a sub-group of the Adult Support and Protection Implementation Group to develop criteria which should be communicated to convenors of Adult Protection Committees for incorporation into local interagency operating procedures.</i>
Validation:	<i>Through case audit in which decisions to address cases through adult protection procedures are presented in relation to the criteria.</i>
Time scale:	<i>Criteria available for consultation April 2010 and made available October 2010.</i>
Result:	<i>Increased consistency of decision making with respect to adult protection interventions across cases, agencies and local authorities.</i>
Reporting:	<i>Adult Support and Protection Implementation sub-group to report to full Implementation Group.</i>

2.2 LOCAL COUNCILS

Under Scottish legislation, local councils have the lead role in implementing and co-ordinating adult protection cases. They have also typically taken the lead in working with partners in establishing interagency operating procedures and training and staff development. Responsibilities in local councils are divided between a number of departments and the research indicated strengths and weaknesses associated with these different components. We consider in turn the roles of commissioners/contract departments, adult protection units or designated adult protection council officers, departments responsible for staff development and training and Adult Protection Committees.

2.2.1 COMMISSIONERS

The research indicated a close relationship between the quality of the commissioning of a service and the subsequent adequacy of adult protection practice provided by that service. There is a close link between a good quality service based on effective management and leadership coupled with appropriate training, on the one hand, and an ethos that precludes the harm of service users, on the other. A failure on the part of commissioners to ensure these characteristics set the scene for a harmful environment by: (a) lack of consideration of the tendering agency's competence in the area of provision; (b) failure to establish the potential local availability of competent staff resources; and (c) failing robustly to establish the adequacy of the agency's adult protection operating procedures. The development of such services is fundamental to adult protection in managed settings and effectively provides the environment in which specific protective measures come into play.

In commissioning services for adults at risk of harm, the implicit relationship between service quality as reflected in (a)-(c) above should be explicitly reviewed in order to safeguard service users from harm (Recommendation 3).

Recommendation 3: In commissioning, designing and monitoring (inspecting) services for adults at risk of harm, the implicit relationship between service quality (as reflected in management and staff competence and attitudes) and adult protection should be explicitly reviewed in order to safeguard service users from harm.

Aim: *To ensure that a comprehensive appraisal with respect to adult support and protection is undertaken that establishes the competence of an agency tendering for a service for individuals at risk harm to deliver such a service in a way that fully safeguards service users.*

Action:	<i>Local authorities to review their commissioning procedures to ensure that evaluation of tenders explicitly assesses the agency's demonstrated competence in: the area of provision; the availability of staffing resources in the locality; and the adequacy of the agency's adult support and protection operating procedures and staff induction, training and support.</i>
Validation:	<i>The review process with respect to adult protection should be submitted to the relevant Adult Protection Committee which will determine the adequacy of this aspect of the commissioning process with respect to adult protection.</i>
Time scale:	<i>Review process to be stated in January 2010 and reviewed by the relevant Adult Protection Committee by March 2010.</i>
Result:	<i>Adult Protection is transparently and robustly integrated into evaluation of tenders for services for adults at risk of harm.</i>
Reporting:	<i>Achievement of aim to be reported in Adult Protection Committee biennial report.</i>

2.2.2 ADULT PROTECTION UNITS AND DESIGNATED ADULT PROTECTION COUNCIL OFFICERS

In most cases reviewed in the research the social work department adopted, though not always effectively, the role of lead agency and/or this role was explicitly accepted by other agencies involved. How the case was conceptualised could only be inferred from the actions documented in case records as clarified in interviews. What we mean here by "conceptualised" is whether the case was formally designated as an adult protection case or was dealt with in the context of case management or through other means, or indeed, was dismissed as involving no risk or protection issues. This applied particularly to allegations of harm in domestic settings in which in a number of cases protective measures were never construed as "adult protection". Instead they were essentially seen as amenable to care management. One consequence was that allegations of abuse continued for as long as 15 years in one case without decisive action being taken.

We would suggest that the process and strategy of inquiries into allegations of harm should be defined at the outset of the case in the light of the responsibilities and operating practices of the various agencies. In addition, (Recommendation 4) in leading the development of protective action, council officers should be explicit as to how the case is conceptualised, i.e. whether in terms of formal adult protection measures or whether protection is seen to be the outcome of a non-formal adult protection approach. With respect to the latter, the criteria that would have to be met to reframe the case as a formal

adult protection case should be stated as this may be necessitated by later events.

Recommendation 4: In leading the development of protective procedures, council officers should be explicit on how the case is conceptualised whether (a) in terms of adult protection measures explicitly, (b) protective measures taken in the context of care management, or (c) no adult protection issues identified. In the event of (b) or (c) criteria should be set as to when a repetition of (b) and/or (c) will automatically trigger (a), i.e. formal adult protection proceedings. These decisions and the reasons behind them should be recorded and tracked (i.e. (a), (b) and (c)) in adult protection recording.

Aim: *To ensure that clear criteria for engaging in adult protection procedures or otherwise are set and recorded and documented in the context of adult protection records.*

Action: *Adult protection officers and units ensure that criteria are stated in interagency operating procedures, recorded, and can be accessed during adult protection audits.*

Validation: *Through analysis of outcomes following (a) to (c).*

Time scale: *Incorporated into interagency adult protection operating procedures by April 2010.*

Result: *Decision making process will be evaluated and long term outcomes documented and may be audited.*

Reporting: *Lead council officer reports as part of case audit process to Adult Protection Committee.*

As part of this initial statement on how the case is to be managed, a clear communication strategy should be articulated to ensure that where appropriate interagency partners have the opportunity to contribute to and benefit from the on-going adult protection process. The local authority should take responsibility for this strategy in consultation with partners. It is anticipated that the development of interagency data sharing protocols and software will in due course document both implementation of the strategy and its realisation (Recommendation 5).

Recommendation 5: As part of management of the case, a clear communication strategy with respect to all agencies' dealings with the alleged victim and her or his family should be articulated to ensure that where appropriate they have the opportunity to contribute to and benefit from the on-going adult protection process.

Aim: *To facilitate interagency communication during the course of the adult protection case.*

Action: *The lead council officer will in consultation with partners in the relevant agencies plan and state the communication strategy determining the means by which data sharing will be undertaken.*

Validation: *Case by case review during and after intervention by involved agencies led by social work.*

Time scale: *Planning for the process to be completed by March 2010.*

Result: *A clear audit trail on interagency communication will be available permitting evaluation of the effectiveness of interagency working.*

Reporting: *Development to be reported to Adult Protection Committees as part of wider reporting on operating procedures.*

There were a number of examples of cases in which allegations of harm were not evaluated by social workers in their own right but responded to with respect to the status or credibility of the person making the allegation. There are obvious dangers in basing responses on such sources, though where allegations were clearly implausible or lacked credibility through repetition the response was understandable. However, we recommend that all allegations are recorded and given due weight and reasons for not proceeding should be stated (Recommendation 6).

Recommendation 6: All allegations of harm to adults who are at risk should be evaluated in their own right and not responded to entirely in relation to the status or credibility of the person making the allegation. Decision making at this point should be formally recorded.

Aim: *To ensure all allegations are given due weight in decisions as to whether to proceed with an adult protection inquiry.*

Action: *Operating procedures specify that all allegations are recorded with reasons related to alleged's credibility/status noted, and reasons for not proceeding with an inquiry justified.*

Validation: *In reviewing adult protection operating procedures Adult Protection Committees should expect a clear statement regarding allegations of harm which were not investigated because of credibility or status of the person making the allegation.*

Time scale: *Adoption of operating procedure by April 2010.*

Result: *Operating procedures and recording make explicit provision for recording status of alleged and any reason for not proceeding on basis of allegation.*

Reporting: *Adult Protection Committee's biennial report to take account of this aspect of procedure in reviewing adequacy of operating procedures.*

Attendance at case reviews, case conferences and adult protection meetings was highly variable with respect to interagency attendance and with regard to attendance of the alleged victim of harm. Decisions to exclude the latter were typically made without reference to the person, based on assumptions regarding their putative capacity and tolerance of stress caused by the discussion. In the light of concerns regarding the human rights of adults who are subject to protective measures this is of particular concern. In principle, it is clearly desirable that an individual should have the opportunity to contribute at such meetings. There should therefore be a clear statement of principles regarding grounds for exclusion of alleged victims from an adult protection meeting, particularly from case conferences and other decision-making forums. Such principles need to be incorporated into operating procedures, as suggested in Recommendation 7.

Recommendation 7: *There should be clear principles regarding who is permitted to exclude whom from the adult protection meetings, particularly at case conferences and other decision-making forums, particularly with reference to the adult at risk of harm.*

Aim: *To ensure that decisions regarding the attendance of the alleged victim at adult protection and related meetings are based on clear criteria which are applied transparently and are specified in operating procedures.*

Action: *Operating procedures should specify the criteria for inclusion and exclusion of alleged victims at adult protection and related meetings.*

Validation: *In reviewing adult protection operating procedures from whichever agency, Adult Protection Committees should expect a clear statement regarding the criteria for inclusion/exclusion of the alleged victim of harm.*

Time scale:	<i>Adoption of operating procedure by April 2010.</i>
Result:	<i>Opportunity of alleged victims to contribute to adult protection meetings is optimised and grounds for exclusion are specifically justified.</i>
Reporting:	<i>Adult Protection Committee's biennial report to take account of this aspect of procedure in reviewing adequacy of operating procedures.</i>

Recourse to legal action during the course of an adult protection case almost entirely involved seeking welfare guardianship under the *Adults with Incapacity (Scotland) Act 2000*. This typically came under consideration because the agencies responsible considered they lacked the power to intervene at the level required because of a variety of constraints. However, the options for managing the case that would become available should guardianship be gained by the local authority were often unclear. How would guardianship be employed? Would obtaining it alter in any way strategies already deployed or available? In pursuing legal provision its implications for the protective strategy and the rights of the individual should be explicitly stated as part of the overall strategy formulated (Recommendation 8).

Recommendation 8: In taking legal action in an adult support and protection case, the protective strategy and associated risk assessment should be explicit on the role the changed legal powers of the local authority and the status of the individual will play, and at what stage of future developments.

Aim:	<i>To ensure that where guardianship is sought under the Adults with Incapacity (Scotland) Act 2000, the implications for both management of the case and ensuring the least restrictive intervention should be stated.</i>
Action:	<i>Operating procedures should specify the ways in which acquisition of guardianship will lower risk and the actions to be taken to ensure these outcomes.</i>
Validation:	<i>In reviewing adult protection operating procedures Adult Protection Committees should expect a clear statement regarding the criteria for seeking guardianship as a protective measure.</i>
Time scale:	<i>Adoption of operating procedure by April 2010.</i>
Result:	<i>Where guardianship is sought the implications for the protective strategy and the delivery of the least restrictive intervention to the alleged victim will be ensured.</i>

Reporting: *Adult Protection Committee's biennial report to take account of this aspect of procedure in reviewing adequacy of operating procedures.*

With two notable exceptions there was an absence of any attempt to draw together agencies' experiences of the cases and learn from them. In only a small minority of cases was any attempt made to get closure. The importance of such closing reviews cannot be overemphasised. First, there is the opportunity in an interdisciplinary setting to identify processes that were and were not successful in protection and in resolving the case. These processes will have occurred both within agencies and between agencies providing in the latter the opportunity to review operating practices and communications. Second, they provide an ideal opportunity for agencies to evaluate differences in approach that bear directly on increasing understanding of cultural and procedural differences among agencies.

In the heavily pressurised context of human services, the motivation to undertake such reviews may often take second place to engaging with new cases and (wrongly) be viewed as unproductive use of time. We therefore make two recommendations. The first is that such reviews should be built into the overall process of adult protection and conducted as a matter of course (Recommendation 9). The second is that Adult Protection Committees should include in their programmes of work reviews of a subset of cases that the involved professionals judge to illuminate strengths and weaknesses of adult protection processes. Such information will inform both the committee's development of protective processes and indicate areas for training and staff development.

Recommendation 9: *Interagency adult protection procedures should require a concluding summary review of all adult protection cases and dissemination of lessons learnt to practitioners and those responsible for training and staff development.*

Aim: *To ensure that lessons learnt in an adult protection case are drawn, recorded and inform future cases.*

Action: *Responsible officer to incorporate this requirement into adult protection operating procedures.*

Validation: *Staff across agencies in subsequent cases apply lessons learnt.*

Time scale: *To be incorporated into adult protection operating procedures during preparation or revision.*

Result: *Adult protection cases are more effectively managed.*

Reporting: *Adult Protection Committee's biennial report to take account of this aspect of procedure in reviewing adequacy of operating procedures.*

In a majority of cases family involvement was significant and the needs of family members other than the individual at risk of harm themselves were identified. Indeed, in some cases adult family members were judged to be at risk of harm, though there were no instances of formal adult protection procedures being undertaken on their behalf. However, these needs could detract from the thoroughness with which protection from harm was undertaken with respect to the principal individual. We therefore recommend that procedures adopted should maintain the imperative to protect the individual at risk of harm regardless of the competing needs of other family members (Recommendation 10). *However, where necessary full adult protection procedures may need to be initiated where the other adult(s) are at risk of harm and meet the criteria of an adult at risk of harm as stated in the Act.*

Recommendation 10: While several family members may be considered clients, in the context of adult protection proceedings the autonomy of the individual (or individuals) considered at risk must remain distinct from wider concerns and specific protective measures must be monitored in their own right.

Aim:	<i>To ensure that competing needs of adult family members do not weaken adult protection measures for the principal adult at risk of harm.</i>
Action:	<i>Clear and distinctive statement of all relevant family needs with the integrity of those of the principal individual at risk of harm preserved.</i>
Validation:	<i>Case audit documents show that support for individual at risk of harm remained paramount.</i>
Time scale:	<i>Determined by staff training initiatives and revision of adult protection operating procedures.</i>
Result:	<i>Allegations and interventions will be conducted in optimal timescale.</i>
Reporting:	<i>Adult Protection Committee's biennial report to take account of this aspect of procedure in reviewing adequacy of operating procedures.</i>

2.2.3 COUNCIL STAFF DEVELOPMENT/TRAINING/EDUCATION DEPARTMENTS

Lead officers in several cases acted on the basis of an inadequate understanding of (a) the legal options available for adult protection; (b) an understanding of the role of the police. A specific example of each will suffice. There were several examples of consideration of welfare guardianship under the *Adults with Incapacity (Scotland) Act 2000* in cases in which it was apparent (and subsequently established) that the individual did not lack

capacity. With respect to reporting to the police, lead social workers on occasions themselves made judgements regarding that there was insufficient evidence for the police to investigate and did not report allegations to the police.

In the context of wider training with respect to the *Adult Support & Protection (Scotland) Act 2007*, staff development/training/education departments should also in Level 3 provide training on the wider legal context and the interdependency of the various Acts relevant to adult protection (Recommendation 11). In addition, training in the role of the criminal justice system in adult protection with special reference to that of the police should be explicitly covered (Recommendation 12).

Recommendation 11: Following intensive on-going training of professionals in the *Adult Support & Protection (Scotland) Act 2007*, training on the wider legal context and the interdependency of the various relevant Acts needs to be developed for key adult protection staff.

Aim: *To ensure interagency staff are informed of legislation relevant in adult protection cases and informed on legal actions to be pursued.*

Action: *Staff development/training/education departments should review Level 3 training material with respect to information on legislation and undertake appropriate training.*

Validation: *Through post-course evaluation of training outcomes and audit.*

Time scale: *To be undertaken in the context of on-going and refresher training in adult protection by July 2009.*

Result: *Interagency staff will pursue legal interventions in full knowledge of the scope and outcome of relevant legislation.*

Reporting: *Adult Protection Committee's biennial report to take account of this aspect of procedure in reviewing adequacy of operating procedures.*

Recommendation 12: As part of adult protection training, the circumstances that are required for a report to be made to the police should be clearly defined and the potential role of the police in adult protection cases clarified for non-police staff.

Aim:	<i>To ensure that in the light of allegations received or evidence arising from any enquiry, social workers and relevant council officers are clear on the criteria for reporting to the police and the subsequent police action to be expected.</i>
Action:	<i>Staff development/training/education departments should review Level 3 training material to ensure that staff understand their role with respect to interagency working with the police and the role of the police in adult protection investigations.</i>
Validation:	<i>Through post-course evaluation of training outcomes.</i>
Time scale:	<i>To be undertaken in the context of on-going and refresher training in adult protection by July 2010.</i>
Result:	<i>Social workers and council officers will have a full understanding of their interagency relationship with the police and the role of the police in adult protection cases.</i>
Reporting:	<i>Adult Protection Committee's biennial report to take account of this aspect of practice in reviewing adequacy of operating procedures.</i>

2.2.4 ADULT PROTECTION COMMITTEES

Independent advocacy was thin on the ground in the cases studied. Such representation is required not only in formal meetings, but in the life of the individual and indeed beyond the conclusion of the adult protection case. There are funding and capacity-building implications for independent advocacy in adult protection cases, as well as a need to clarify what model of advocacy should be adopted (Recommendation 13).

Recommendation 13: Adult Protection Committees should take the initiative in facilitating the design of appropriate independent advocacy services working in collaboration with local advocacy services, ensuring that resources available for adult protection measures are extended equitably to this aspect of support.

Aim:	<i>To ensure the availability of independent advocacy in cases of adult protection in which the individual at-risk of harm lacks independent support.</i>
Action:	<i>Adult Protection Committees to convene an advocacy sub-group to review with local advocacy services plans for independent advocacy in adult protection cases and the resource implications necessary to establish such provision.</i>

- Validation:** *Review of advocacy provision as part of preparation for the independent convenor's biennial report.*
- Time scale:** *Advocacy sub-group to be convened by March 2010 and report to the Adult Protection Committee by June 2010.*
- Result:** *A comprehensive plan for advocacy will be formulated and the resource implications determined.*
- Reporting:** *Adult Protection Committee's biennial report to review adequacy of advocacy provision.*

We have already recommended (Recommendation 9) that a final case review and summary should be undertaken. This may take the form of a formal audit and these should be made available to the Adult Protection Committee which should review outcomes and develop adult protection practice accordingly (Recommendation 14).

Recommendation 14: Adult Protection Committees under the guidance of practitioners and through identification of significant cases should undertake a subset of case reviews and incorporate relevant insights into development of adult protection policy.

- Aim:** *To ensure that the implications of significant cases for future adult protection practice are clearly identified.*
- Action:** *Adult Protection Committees should establish the criteria as to what constitutes a significant case and review such cases on a regular basis.*
- Validation:** *Through analysing the impact of significant case review on adult protection operating procedures.*
- Time scale:** *Setting of significant event criteria and procedures for reviewing such cases completed by March 2010.*
- Result:** *Adult protection operating procedures are reviewed and revised making them more fit for purpose.*
- Reporting:** *Adult Protection Committee's biennial report to review development of operating procedures in light of revisions arising from significant case reviews.*

Both victims and alleged victims in the cases studied were extremely diverse. How they were approached and dealt with in the cases was obviously conditioned by their characteristics both with respect to their capacity and personality as well as the circumstances in which they lived. The pervasive feeling in reading the case files and listening to the interviewees was that though harm remained unproven in most cases, there was significant cause for concern and a good probability that harm had occurred.

The behaviour of an individual could lead to an increased risk of harm, though this in no way implies blame on that individual. Though the person may lack insight into how their own behaviour might put them at risk, consideration has to be given to how, through training and support such behaviour may be changed to lower risk. More broadly, increasing awareness through education and training is a further dimension of adult support and protection that should be implemented.

Recommendation 15: Adult Protection Committees should as part of their review of local adult support and protection policies request information on initiatives to enhance protection through awareness raising of individuals at risk of harm and develop appropriate initiatives with council staff development/training/education/departments and other statutory and voluntary agencies.

Aim: *To support people at risk of harm whose own behaviour increases the probability that they will be mistreated.*

Action: *Adult Protection Committee to request information from relevant service providers, advocacy services and other relevant agencies what initiatives have been undertaken to enable those at risk of harm to protect themselves.*

Validation: *Evidence of interventions to achieve this aim.*

Time scale: *Review to be undertaken by March 2010.*

Result: *Adults at risk of harm are better able to protect themselves from mistreatment.*

Reporting: *Outcome of review with recommendations to form part of the Adult Protection Committee's biennial report.*

Individuals who have been harmed, mistreated and/or neglected require support. Examples were found of excellent follow up treatment and support, provided both individually and to groups. Such support generally was provided through social work support, but also occasionally through health service counselling and treatment. In some cases continued care management sufficed while in others an intervention focused on the consequences of the harm through counselling or therapy was provided. Recommendation 16 suggests that explicit consideration should be given to the victims' or alleged victims' therapeutic needs in the aftermath of adult protection cases whether the allegations were formally substantiated or not.

Recommendation 16: Adult Protection Committees should determine that adequate post-case assessments of the psychological and emotional needs of victims and alleged victims have been carefully conducted and that resources are available to meet those needs through appropriate counselling and therapy.

Aim: *To ensure victims of harm receive appropriate support through counselling and therapy.*

Action: *Adult Protection Committee to (a) request information from relevant service providers, advocacy services and other relevant agencies regarding what support is available to harmed individuals and (b) to ensure that such information is included in case audits; review follow-up support as part of the audit process.*

Validation: *Provision of evidence that effective counselling and support is provided in cases where emotional or psychological damage has resulted from harm.*

Time scale: *Adult Protection Committee's review to be completed by July 2010.*

Result: *Individuals subjected to harm are better able to cope emotionally and psychologically with the trauma resulting from mistreated.*

Reporting: *Review of supportive provision to be undertaken by Adult Protection Committee and reported in biennial report.*

2.3 SERVICE PROVIDERS

It is critical that those in frontline services are clear on their obligation to report suspicions of, or allegations of, harm and how and to whom such reports should be made. There was some confusion among care home managers and staff in this respect, with significant delays in reporting occurring. While provider agencies generally had adult protection guidelines, these are of little relevance unless accompanied by effective training in which staff internalise the adult protection message as well as knowing how to act when such situations arise. Obstacles to whistle blowing were noted, including lack of clarity as to what constitutes harm, fear of anonymity not being guaranteed, as well as fear of repercussions. Recommendations 17 and 18 address these issues. Both recommendations are particularly relevant to the Care Commission's stated aim of assessing policies and procedures².

² Care Commission (2008) *Adult Support and Protection Policy and Procedure*. Dundee: Scottish Commission for the Regulation of Care.

Recommendation 17: Commissioners should establish that managers and staff of service providers are fully familiar with their agency's adult protection policy and procedures, not simply that such policies have been developed.

Aim: *To ensure that the managers and staff in managed settings fully understand what action to take and what procedures to follow in the event of allegations of harm affecting their service users.*

Action: *Training in adult protection procedures should be assessed by commissioners and audited as part of service reviews by the local authority.*

Validation: *Evidence is provided by service providers that managers and staff are fully familiar with adult protection procedures related to their service providers and made available to Adult Protection Committees.*

Time scale: *Adult Protection Committees should request this information is available by July 2010 and thereafter annually.*

Result: *Efficient and effective adult protection procedures become the norm in managed settings.*

Reporting: *To the local authority and the Adult Protection Committee.*

Recommendation 18: Robust and workable whistle blowing policies should be evident in all service settings and staff awareness of them should be an integral part of adult protection training.

Aim: *To ensure that staff working in managed settings have the confidence to know that any allegations of harm they report to the manager will be acted on in conformity with the agency's adult protection procedures and that they will be safeguarded from negative reactions from management, fellow staff members or others.*

Action: *Service providing agencies should be required by Adult Protection Committees to review and report their whistle blowing procedures and ensure that all staff is fully briefed on procedures and consequences.*

Validation: *Information provided by agencies clearly details whistle blowing policies and training initiatives to satisfaction of Adult Protection Committee.*

- Time scale:** *To be initiated April–July 2010.*
- Result:** *Staff working in managed settings has the confidence to report all concerns regarding harm.*
- Reporting:** *Adult Protection Committees to report on whistle blowing review in biennial report.*

Family members almost invariably remained closely engaged with and concerned about their relative in managed settings, including care homes. They might also be the source of complaints regarding the treatment of their relative. For them to contribute to the protective process, it is essential that they are given clear information on the process by which they can make their concerns known. This applies whether the complaint relates to the general quality of care or specifically to an allegation of harm. When complaints are made, this information should be reiterated and support given to them in the reporting process (Recommendation 19).

Recommendation 19: Family members with a relative in a managed setting (i.e. residential, day or respite) should receive information from the service provider on the complaints procedure generally and as to how to proceed if they make allegations of harm. In the event of their expressing such concerns, their right to pursue complaints or allegations and how they should proceed should be reiterated to them.

- Aim:** *To ensure that relatives of alleged victims are familiar with procedures they have a right to follow in the event of concern regarding possible harm.*
- Action:** *Service providers must inform next-of-kin of procedures orally on admission of the relative and provide written information in a language and form appropriate.*
- Commissioners for the service must ensure that this requirement is part of the service contract.*
- Validation:** *Review/inspection of service by commissioner or Care Commission.*
- Time scale:** *Practice to be introduced from January 2010 with relatives of existing service users informed by April 2010.*
- Result:** *Relatives of individuals at risk of harm are informed of their rights regarding their course of action in the event of concern regarding their relative.*
- Reporting:** *Implementation of this policy should be reported by commissioners to the Adult Protection Committee.*

2.4 POLICE

There were significant delays in reporting allegations of possible criminal acts to the police, and in some cases such delays may have compromised investigations. There are many reasons for such delays, some based on assumptions about police procedures or conditioned by the desirability of dealing with the allegations through other means. The circumstances in which referral to the police is appropriate need to be clearly stated. We recommend that the police contribute to training of non-police staff with respect to the legal and procedural context in which the police operate, and their expectation of their interagency partners (Recommendation 20).

Recommendation 20: As part of adult protection training, the police should contribute to training with respect to the circumstances that are required for a report to be made to the police and their potential role in adult protection cases clarified to other agencies.

Aim:	<i>To ensure that non-police staff involved in adult protection cases are clear on the role of the police in investigations of allegations and the relevant procedures with respect to their communications with the police.</i>
Action:	<i>Police training departments to liaise with training departments in the local council and NHS training departments to deliver training to relevant staff.</i>
Validation:	<i>Training to be evaluated pre- and post course.</i>
Time scale:	<i>Training to be delivered May-September 2010.</i>
Result:	<i>Adult Protection non-police staff will understand their own role and necessary actions with respect to communicating with the police and the scope of police activity in cases.</i>
Reporting:	<i>Training and its outcome to be reported to Adult Protection Committee as part of overall appraisal of training.</i>

With respect to police investigations, we make two recommendations (Recommendations 21 & 22). First, we noted that police investigations were sometimes influenced by input from staff in the care setting, i.e. accepting information in a way that precluded fuller investigation. An example was acceptance of the view of staff that the alleged victim lacked capacity and could therefore not be interviewed. Second, the police in some cases commented on the standard of care in the service setting. The status of their knowledge and expertise to do so was unclear, as was the bearing this had on the case.

Recommendation 21: In conducting an investigation into allegations of harm, the police should independently evaluate any information regarding the alleged victim and alleged perpetrator rather than accepting information from third parties at face value, however credible. In all cases steps should be taken to interview/communicate with alleged victims/perpetrators adopting advice on how best to communicate from relevant professionals such as speech and language therapists.

Aim: *To ensure that alleged victims and perpetrators rights to participate in any investigation are respected and their opportunity to contribute optimised.*

Action: *Guidance to the police should be provided by the relevant lead officer in the force.*

Validation: *Through information provided for case audit by police personnel.*

Time scale: *Instructions to be issued March 2010.*

Result: *Police optimise probability of collecting all relevant information while the alleged victim of harm is enabled to contribute to their own safeguarding and his/her rights are respected.*

Reporting: *Implementation reported to Adult Protection Committee through police representative.*

Recommendation 22: Where care standards and practices are deemed relevant to a police investigation, steps should be taken to ensure that the investigating officers are familiar with such standards and their implications for adult protection.

Aim: *To ensure that police comment on care are informed by an understanding of national care standards.*

Action: *Local authority training/staff development departments conduct short training sessions for police on national care staff and evidencing compliance with them.*

Validation: *Through information provided for case audit by police personnel.*

Time scale: *Training to be conducted January-September 2010.*

Result: *In commenting on care standards as part of their report on investigations, police observations are made in the light of actual care requirements.*

Reporting: *Outcome of training reported to Adult Protection Committee as part of overall training review.*

A particular source of dissatisfaction of social workers, but also families, was the failure of police to provide feedback on the course and outcome of an investigation. This difficulty may be resolved in the context of data sharing. However, the following recommendation reinforces this requirement explicitly (Recommendation 23).

Recommendation 23: **Police engaged in an adult protection related investigation should inform the relevant council officer of progress with respect to key phases of the investigation, i.e. interviews conducted and decisions taken with respect to progressing the case or otherwise.**

Aim: *To enable non-police personnel involved in adult protection cases to act in an informed way with respect to police involvement.*

Action: *Requirements regarding communication to be incorporated into police and interagency operating procedures.*

Validation: *Through review of police/interagency operating procedures by Adult Protection Committee.*

Time scale: *Police/interagency operating procedures to be revised by April 2010.*

Result: *Personnel involved in adult protection cases are fully informed of police activity as they undertake their own work.*

Reporting: *Report to Adult Protection Committee as part of reviews of interagency operating procedures.*

2.5 NATIONAL HEALTH SERVICE

Professionally, health provision is multifaceted with widely different modes of interaction in adult protection cases by health care professionals. GPs, for example, within the limits of their working practices, i.e. patient consultations and attendance at adult protection reviews, *did* exhibit concern for individuals' overall wellbeing and that of the family. Community psychiatric nurses while undertaking professional assessments were fully engaged with individuals at risk. With respect to other health professionals, e.g. psychiatrists and clinical psychologists, the input required reflected expertise in assessment or treatment usually requested by social workers but sometimes by other colleagues in interagency teams. Specific examples were respectively the many cases where requests for assessment of capacity or psychosexual counselling were made. This expertise differs from that of social workers and what is critical is the way in which the very diverse types of health intervention

are integrated into the process of adult protection, not that healthcare professionals somehow become a parallel stream with the same adult protection culture and practice as social work. This is not to say that a shared value system with respect to the prevention of adult harm should not be regarded as essential. While any member of NHS staff may become involved in an adult protection case, GPs, community psychiatric nurses, psychiatrists, psychologists and speech and language therapists were most frequently involved in the cases studied, and within the NHS most likely to contribute together. There is a need to increase the group identity of NHS staff principally involved in adult protection (Recommendation 24).

Recommendation 24: In formulating interagency policies, health service input to interagency working needs to be formulated in such a way that the complementary roles of NHS staff with respect to the prevention of harm and its physical and mental consequences are viewed in a more integrated way.

Aim: *To develop a core of staff with an adult protection identity within NHS staff, a virtual team with the capacity to work with the lead local authority officer in a flexible but integrated way.*

Action: *Senior NHS management to review involvement of NHS staff to be undertaken based on on-going case audits to identify such a core of professionals in each NHS area and take steps to develop this core as an identifiable network.*

Validation: *Completion of this process will result in the identification of the NHS adult protection network across specialties and professions.*

Time scale: *To be undertaken over a six month period, March-September 2010.*

Result: *Interagency working will be facilitated by the clear identity of the network of professionals in the NHS with close links to adult protection interventions.*

Reporting: *To the relevant NHS Board and the Adult Protection Committee.*

3.6 CARE COMMISSION

Prior to the passing of and implementation of the *Adult Support and Protection Act (Scotland) 2007* the Care Commission had published its own *Interim Procedure for Care Commission Staff in Respect of Adult Protection*

(Care Commission 2007³). (This document has been superseded by a post-Act policy and procedure document⁴.) The twin, but closely related, elements of adult protection are expressed as: “...to provide the mechanism whereby Care Commission staff can consider adult protection matters, both in the context of assessing the policies and procedures of providers and in responding to adult protection concerns they may come across in their day to day work.” (p.3). The document explicitly acknowledges social work departments as the lead agency and directs “...the immediate notification of the relevant social work department...” (p.10) in the event of allegations. In parallel, the police may also be notified. Care Commission involvement in the cases studies effectively and at times meticulously followed this guidance.

There were, however, a few procedural shortcomings. In three cases the role of the Care Commission as perceived internally by staff was unclear with a significant disagreement between staff in one case. Co-ordinated working with the social work department was not evident in some cases. Given that the Care Commission adult protection procedures are clearly stated and well developed, it is obviously important that commission staff are fully cognisant with them; it also critical that at local level partner agencies, particularly the social work department and police, also understand the role and operation of the commission. Working practices consistent with both sets of guidelines (commission’s and interagency’s) need to be clearly articulated and their operation should form part of case audits (Recommendation 25).

Recommendation 25: Care Commission staff should initiate through the appropriate Adult Protection Committee a review to determine that training in key agencies covers the role and operating procedures of the Commission in adult protection cases.

Aim:	<i>To ensure that all interagency partners and their staff are familiar with the Care Commission’s own operating procedures in relation to their own procedures.</i>
Action:	<i>Training should be initiated through the Care Commission and undertaken by the relevant staff development/training section of each partner agency.</i>
Validation:	<i>Evidence is provided to the Care Commission that such training has been conducted and evaluated as effective.</i>
Time scale:	<i>Training should be initiated from May 2010 onwards.</i>
Result:	<i>Efficient and effective adult protection procedures become the norm in managed settings.</i>

³ Care Commission (2007) *Interim Procedure for Care Commission Staff in Respect of Adult Protection*. Dundee: Scottish Commission for the Regulation of Care.

⁴ Care Commission (2008) *Adult Support and Protection Policy and Procedure*. Dundee: Scottish Commission for the Regulation of Care.

Reporting: *By staff development/training departments and the Care Commission to the Adult Protection Committee.*

3 Scope of the recommendations

As noted at the outset of this report, the impetus given to improving practice in the field of adult support and protection in Scotland through implementation of the *Adult Support and Protection (Scotland) Act 2007* in 2008 has already led to extensive developments in this field. For some agencies some of the recommendations made above may already have been met. However, we are very aware that this is not universally the case and improvement in this area must be an on-going process for many years to come.

We suggest that Adult Protection Committees review the research and recommendations and decide which would be most relevant to local practice enabling them to prioritise their implementation.

We are also aware that though the recommendations are compartmentalised by agencies or committees, in reality most require collaborative interagency working. The location of a recommendation in the report should therefore be seen as indicating who principally should take the initiative, and not taken to indicate exclusive responsibility.

The expectation of those working in the field of Adult Protection in Scotland is that the *Adult Support and Protection (Scotland) Act 2007* will lead to significant improvements in safeguarding adults at risk of harm and in responding to concerns of harm. To ensure that the resulting improvements are fully realised, attention to the details of adult protection processes is essential. It is hoped that the present recommendations make a contribution to this progress.



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